| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155385 | A. BUILDING **02**<br>B. WING _____ | R<br>**02/12/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CAMELOT CARE CENTER** | **1555 COMMERCE ST**<br>**LOGANSPORT, IN 46947** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS | {K 000} | | |

A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/16/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 02/12/14

Facility Number: 000466
Provider Number: 155385
Aim Number: 100289810

Surveyor: Phillip Komsiski, Life Safety Code Specialist

At this PSR survey, Camelot Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and with battery operated smoke detectors in all resident rooms. The facility has a capacity of 75 and had a census of 60 at the time of this survey.

All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the facility had one detached wood shed which is used to store

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| {K 000} | Continued From page 1<br>activities supplies.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/17/14. | {K 000} | | |